



Displaced Intrauterine Contraceptive Device Management through Rectal Rout

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General Note



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ABSTRACT

Intrauterine contraceptive device (IUCD) has become widely used between childbearing age group for birth control. However we might face displacement of IUCD, which may lead to migration of IUCD extra-uterine and eventually perforation, will take a place. We reported a 34 years old lady (p3+1) presented to emergency department with heavy per vaginal bleeding after 2 months of missing period. Vaginal examination revealed opened os with clots. IUCD was not seen in Ultrasound examination. Computerized Tomography scan (CT) was done on next day and showed that the missed IUCD was outside the uterus in the pelvic. Laparoscopy

identified the thread and the rest of the device was inside the rectum .the device was pulled through rectum by long artery forceps with no significant rent felt. Conclusively, IUCD is a safe method for contraception but perforation and migration could happen and it is important to do rectal exam along with other investigations if needed and it could be safely removed through the rectum without complications or the need of colostomy.

Keywords: Intra-uterine contraceptive device, perforation, rectum, Laparoscopy, colostomy.

1. INTRODUCTION

Many women preferred to use intrauterine contraceptive device (IUCD) because it is safe and provide long term method for contraception. As such, it has become widely used between childbearing age group for birth control (IKLAKI, Agbakwuru, Abeshi, 2017). Common symptoms after insertion might include abdominal pain, infection or expulsion (Yoost, 2014). However we might face other complications such as displacement of IUCD, which may lead to migration of IUCD extra-uterine and eventually perforation will take a place (Aghaways , wahid, Ali , Saber, Kakamad, 2016). The incidence rate of IUDs-induced perforation ranges from 1.2 to 6.8/10,000 insertions (Boudineau M, Multon O, Lopes P, 2001; Broso PR, Buffetti G, 1994). Usually women presenting with uterine perforation experience pelvic pain and/or vaginal bleeding, rectal bleeding, peritonitis, unwanted pregnancy, intestinal obstruction and in some case they may be asymptomatic, and discovered accidentally through examination by observing absence of the IUCD string at the external os of the cervix (Weng SF, Chen HS, Chen YH, Lee JN, Tasi EM, 2011).

We reported a case of 34 years old healthy female para 3 plus 1 who found to have displaced IUCD extrauterine following dilation and curettage on top of IUCD, managed without complications through rectal rout.



Figure 1 Pelvic Ultrasound showing cervix was opened and measured approximately 1.3CM and IUCD was not seen at time of scan.

2. CASE PRESENTATION

During April 2019, a 34 years old lady (p3+1) with all spontaneous vaginal deliveries presented to ER with heavy per vaginal bleeding after 2 months of missing period. Pulse was 98/minutes and blood pressure was 82/52 mm/Hg with sever pallor. Clinical

examination showed soft non-tender abdomen. Vaginal examination revealed opened os with clots. Ultrasound showed 13+6 weeks gestation and IUCD not seen and there was no fetal heart rate (Figure 1). She underwent dilation and curettage and a missed IUCD was not discovered. Then, after stabilization the patient was sent to Radiology department for confirming the place of IUCD. Computerized Tomography scan (CT) was done on next day and showed that the missed IUCD was outside the uterus in the pelvic posteriorly in the right side at the posterior aspect of the pelvis (Figure 2). Patient was discharged home and asked to come after 2 weeks as planned to do laparoscopic for exploration and removal of IUCD. During Laparoscopy, we were able to identify the thread of IUCD so general surgery was involved in management of this patient examination under general anesthesia was done and IUCD was felt 8 cm away from anal margin. Thread was pulled through rectum by long artery forceps with no significant rent felt the perforation was closed using Viracyl suture. Povidone injection through rectum was given to see the spillage in peritoneal cavity after removing the IUCD through rectum and there was no spillage seen. The patient had smooth post-operative recovery and laparoscopy remains uneventful.

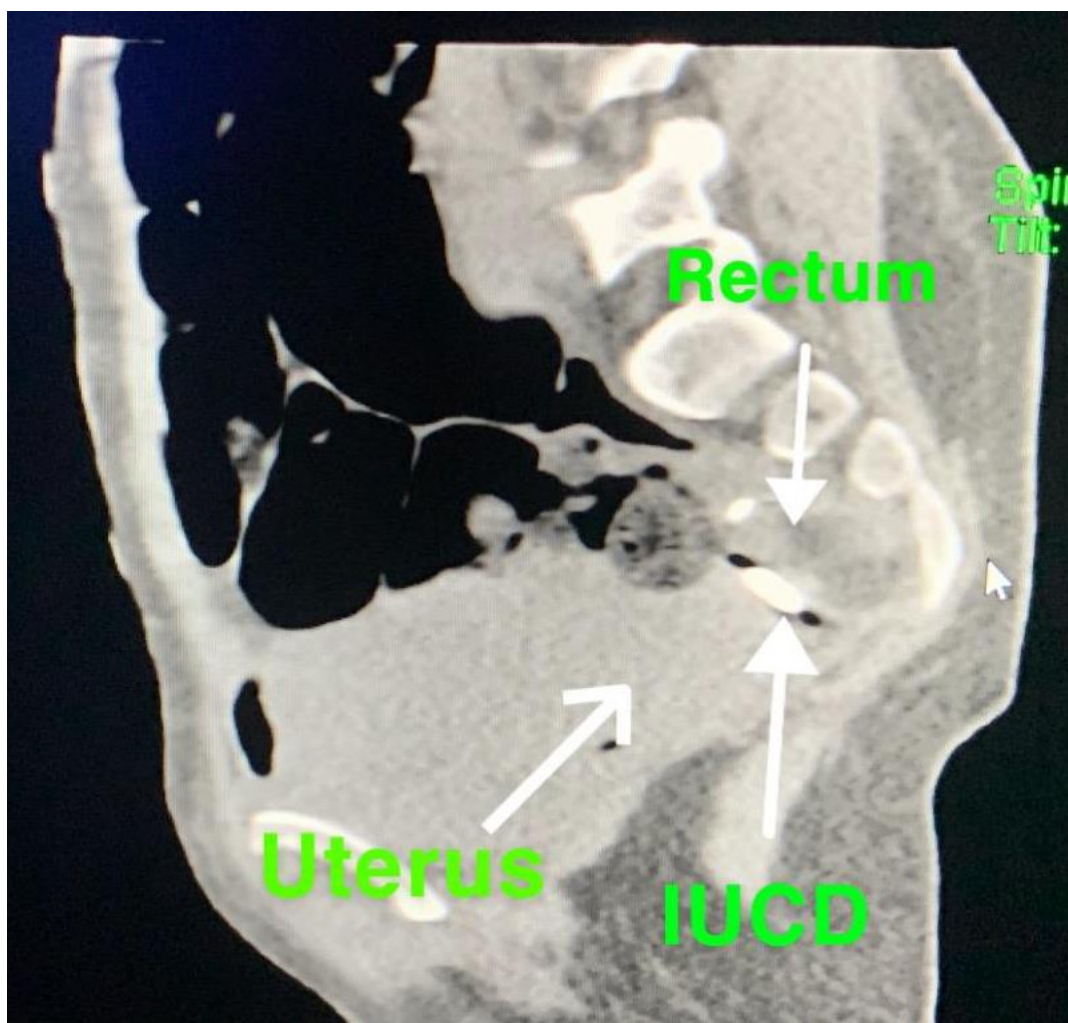


Figure 2 CT pelvis without contrast showing that the IUD is seen outside the uterus in the pelvis posteriorly in the right side at the posterior aspect of the pelvis. There is large swelling seen within the uterus due to bulky uterus which is related to the pregnancy

3. DISCUSSION

One of the most serious complications associated with IUCDs is uterine perforation. Although it is a rare condition, it can lead to severe morbidity and mortality (Caliskan E, Ozturk N, Dilbaz BO, Dilbaz S, 2003). Many women with a translocated IUCD are asymptomatic and recognized only when pregnancy occurs while some others presented with pelvic pain and/or vaginal bleeding (Caliskan E, Ozturk N, Dilbaz BO, Dilbaz S, 2003). The present case was presented with severe vaginal bleeding during pregnancy.

The World Health Organizations (WHO) recommended that any translocated IUCD following uterine perforation should be removed whether symptomatic or asymptomatic irrespective of the location (WHO, 1987). Nearly 15% of uterine perforations by IUCD result in complications in nearby organs, mostly in the intestines (Dean G, Goldberg A, 2010). In the current report, we have presented a rare case in which rectal perforation by an IUCD presented as painless vaginal bleeding during early pregnancy. Some other reports were published. In Taiwan, Weng et al. (Weng SF, Chen HS, Chen YH, Lee JN, Tasi EM, 2011) reported a case presented with painless rectal bleeding during menstruation. In USA, Eichengreen et al. (Eichengreen C, Landwehr H, Goldthwaite L, Tocce K, 2015) reported a case presented one year after IUCD placement with non-visualized strings and the device was found to be penetrating through the rectal mucosa and removed easily through the rectum during an examination under anesthesia. Also in USA, Taras and Kaufman (Taras AR, Kaufman, 2010) presented a woman with a history of IUCD placement 4 years earlier presented with abdominal pain and bright red blood per rectum. Several factors were associated with uterine perforation by IUCD including uterine size and position, timing of IUCD insertion, presence of uterine congenital anomalies or previous surgery as well as the experience of the clinician, are associated with perforation (Weng SF, Chen HS, Chen YH, Lee JN, Tasi EM, 2011).

In the present case, ultrasound and CT were used to determine the location of a perforated IUCD. The same has been reported by others (Weng SF, Chen HS, Chen YH, Lee JN, Tasi EM, 2011; Eichengreen C, Landwehr H, Goldthwaite L, Tocce K, 2015; Taras AR, Kaufman, 2010). It is recommended to immediately remove the dislocated IUCD because it may cause peritoneal or omental adhesions, volvulus, utero-cutaneous fistula and bowel perforation (Kho KA, Chamsy DJ, 2014; Shin DJ, Kim TN, Lee W, 2012).

Therefore, in the present case removal of the penetrating IUCD was done after two weeks. Generally, colostomy usually performed often for perforated or displaced IUCD to the rectum because of the concerns of infections, generalized sepsis, peritonitis and abscess formation. Despite the usual treatment, in the present case, IUCD was safely removed from the rectal route without a need for colostomy.

4. CONCLUSION

IUCD is a safe method for contraception but perforation and migration could happen and it's important to do rectal exam along with other investigations if needed and in this case it could be safely removed through the rectum because the device was mostly inside the rectum so after removal of device was no need to do any colostomy and it was safely controlled with a drain without complications. In addition, clinicians should re-examine the patient 6 weeks after IUCD insertion. The authors have no conflicts of interest.

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Conflicts of Interest:

The authors declare no conflict of interest.

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